Medico-Legal Issues and Documentation For MO



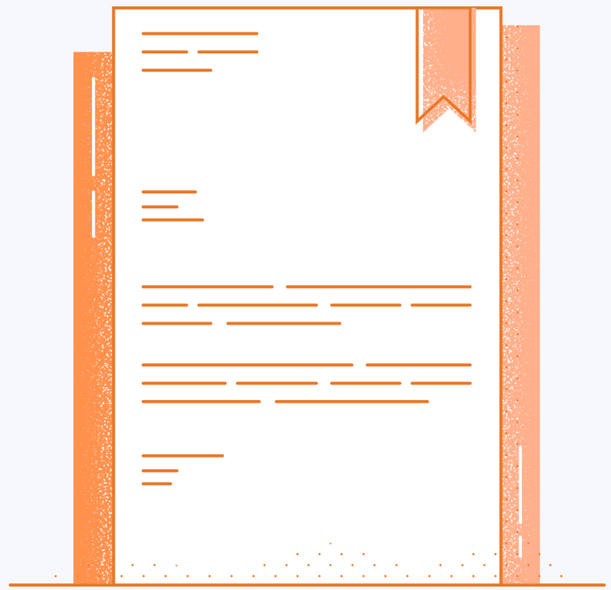



WHAT IS A MEDICO-LEGAL CASE?

All instances where the Medical practitioner learns of Unnatural deaths OR all crimes against human body- accidental or deliberate including animals are considered as a medico-legal case

SOME CAVEATS

- Medical practitioner is bound to give information to the police
- Any clinical case which goes to the court is a medico-legal case.
- Prompt medical attention is to his/her first priority
- Medico legal documentation is an important



ROLE OF THE MO

TAKE	Take appropriate history, clinical examination and documentation would not only result in good record keeping but also would be invaluable evidence in the court.
BE	Be cautions and complete in all his actions
SUBMIT IN	Submit in reasonable time all the reports/specimen for further examination/records to appropriate authorities like the police, forensic science laboratory, court etc.
KEEP	Keep himself/herself updated on all the guidelines / prepare the documents accordingly
PRESENT	Present evidence in the court of law
BE	Be humane and holistic
ACT	Act as an agent of social change by facilitating preventive actions

DOCUMENTS FOR MEDICO LEGAL CASES






- **Medical Certificate:** These are certificates issued by the Medical practitioner which pertain to sickness, insanity, death, age etc. False certification is an offense. Incomplete certificate may also be viewed by the court as concealing information and strictures might be passed by it on the issuing Medical practitioner.

- **Medico-legal report:** These are documents prepared by the medical practitioners in compliance with a written requisition issued by a magistrate or police officer. Medico-legal reports pertain to Injury, Sexual offence, death etc. It contains all the facts observed by the medical practitioner and his/her opinion drawn there-from. The opinion is expected to be made based on the observations and not on hearsay evidence.

- **Dying Declaration:** Is a statement written or oral made by a person who is on the verge of dying as a result of unnatural causes. The statement should relate to the cause of his/her imminent death or any of the circumstances of the transaction resulting in his/her present condition.

TYPES OF CASES TREATED AS MEDICO-LEGAL

All cases of injuries and burns - the circumstances of which suggest commission of an offense by somebody (irrespective of suspicion of foul play);	All vehicular, factory, or other unnatural accident cases specially when there is a likelihood of patient's death or grievous hurt;	Cases of suspected or evident rape/sexual violence;	Cases of suspected or evident criminal abortion;
Cases of unconsciousness where its cause is not natural or not clear;	All cases of suspected or evident poisoning;	Cases referred from court or otherwise for age estimation;	Cases brought dead with improper history creating suspicion of an offense

PROCESS

First and foremost duty of a MO is to treat and save the life x
Information to the police should be sent in a reasonable time except in some cases of sexual violence cases. MLC police information form is filled in triplicate and one copy is handed over to the police person and one copy is retained in the hospital record.
Treatment for medico-legal cases would include both pharmacological/medical/surgical as well as psychosocial treatment, especially in cases of rape/sexual violence and child abuse
MO to conduct medico-legal examination and prepare medico-legal report
Wherever required various specimens are collected, sealed and handed over to the police authorities after sealing the same. A receipt of the items sealed and handed over to the police is taken . In cases of rape/sexual violence of a girl or woman, and in case a female doctor is not available, a male doctor should conduct the examination in the presence of a female attendant
Take the consent of the injured person on the MLR Form. If the patient is less than 12 years, take the consent of the guardian/ accompanying person and get his signature/thumb impression
Patient case file is stamped as medico-legal case

PROCESS

The hospital must designate certain staff responsible for handling evidence and no one other than these persons must have access to the samples

The collected samples for evidence may be preserved in the hospital till such time that police are able to complete their paper work for dispatch to forensic lab test including DNA.

The records should be kept under lock and key, in the custody of the doctor concerned

Preserve all the inpatient records for a period of at least 5 years and outpatient department records for 3 years.

All medico legal case records are to be retained as per state guidelines or by default for lifetime

General Hospital/CHC/PHC_____**District**_____

Medicolegal Case (M.L.C.) information

Time_____am/pm

Date_____

To

The Officer in charge

Police Post/Station,

District_____ I am to inform you that a patient with the following particulars has been brought to the General Hospital/CHC/PHC _____of the district_____ and is being treated/discharged/LAMA has expired in the emergency OPD/_____ ward of the General Hospital/CHC/PHC Name _____ S/o, D/o _____ Age _____ Sex _____ Hospital Central Registration No. _____ Date and time of admission _____ Diagnosis _____ grievous hurt/head injury/burns _____.

MLR attached: Yes/No

Signature
(Name of the Medical Officer)
(in block letter)
_____

Time and of the receiving the information at the police post.
_____

Signature of the Police Officer_____
Name (in capital letters)_____
Seal of the Police Post_____

DYING DECLARATION

A statement by a person who is conscious and knows that death is imminent concerning what he or she believes to be the cause or circumstances of death that can be introduced into evidence during a trial in certain cases.

A dying declaration is considered to be credible and trustworthy evidence based on general belief that a person who is on his deathbed will never lie. It is based on the principle nemo mariturus presumunturmentri meaning a man will not meet his maker with a lie on his mouth.

Declaration made by the deceased person can be in oral, written and by conduct.
“Sir,This day 24th January 1960 in the afternoon at 12:30 Muniappan son kola goundan of kamnav-kurechi stabbed me in my body with a knife.”

DO’s IN RECORDING DECLARATION






- Examine the declarant for Fitness to make the statement and certify.
- Record the statement of the declarant as it is in the language of the declarant.
- Ensure that the declarant is free to make statements with any undue pressure.
- Ask a question or two to get clarity in the statements and record them as it is.
- Record the non-verbal cues, if any, made by the declarant.
- Read out the content of the recordings to the declarant to verify its correctness.
- Take the signature or thumb impression of the declarant.
- Sign on the declaration and takes signatures of witnesses.
- Record promptly any breaks that might occur while giving the statement.

DON’Ts

- Do not administer any oath to the declarant
- The statement should be free and spontaneous without any prompting, suggestion or aid from any person.
- Do not put suggestive or leading questions.
- Do not allow the presence of kith and kin of the declarant while the declaration is being made.
- Do not alter the terms, phrases or the content of the declaration.

RECORDING OF THE DYING DECLARATION

At the time of giving a declaration, the person who's making the statement must be in a ***fit state of mind***
The statement can be recorded by the doctor or by a police officer. But one condition must be coupled with it that while recording the statement there shall ***one or two-person present*** there as a ***witness*** otherwise the Court may find the statement to be suspicious.
The statement made by the deceased may be ***oral or written***. But in some cases it can be made with sign and gesture depends on the condition of the deceased
It should be recorded in the ***language*** of the deceased in which he is fluent. It can be recorded in any language.
If the statement has been made even when no cause of death had arisen then also the statement will be relevant. It is not important at all that the statement recorded should be just before the death of the victim.

DYING DECLARATION

The statement must have:

- Cause of death- when the statement is made by the person as to the cause of his death or as to any of the circumstances of the transaction which was the reason for his death not cover all the incident which are not relevant in order to determine the cause

- Circumstances of the transaction- the statement made by the deceased is only related to the circumstances of the transaction will result in the death of the deceased, remoteness or having no nexus which can not be connected with the transaction have no value.

- Resulted in the death- the deceased statement should have the cause and circumstances that will clearly reason for his death or ultimately result in his death.

RECORDS AND REGISTERS AT PHC –USED FOR EMERGENCY CARE

1. OPD/Treatment Register: One common register for patients of OPD/Emergency containing demographic details along with clinical findings, chief complaint (if any), and provisional diagnosis along with treatment provided.

2. Inventory Register: Should contain information about drugs, consumables, equipment, instruments and consumables available in the health facility with details about their maintenance, consumption and indent.

3. Referral Register: should contain information on referral in/out with reason for referral. Information of follow up of cases also to be recorded.

4. Record for handing over and taking over of critical care equipment all levels.

5. Medico legal register

RECORDS AND REGISTERS AT PHC –USED FOR EMERGENCY CARE

6. Patient/Community feedback register

7. At Risk Register for vulnerable patients in the catchment area

8. Emergency Register: One register for patients of Emergency containing demographic details along with clinical findings, chief complaint (if any), and provisional diagnosis along with treatment provided.

9. Mapping of the Facilities based on the preference of the patients from the community and the healthcare facilities.

REFERRAL SLIP

- Standard referral form with all the required standard information. Along with minimum requirements for information that should be provided with all referral requests, additional information may be provided.

- This additional information may be based on agreement between the consulting and referred doctor or may be provided based on the need at the time of referral.

REFERRAL SLIP

Name of Patient: ..... Age: ..... Yrs: .....

Next of kin or Person Responsible in cases involving minors –
(name, Address and Telephone Number): .....

.....

Address: .....

Unique identification No. : .....

Referred on ...../...../..... (d/m/yr) at ..... (time) to .....

.....(Name of the facility) for management.

Provisional Diagnosis/Key symptoms:

Admitted in the referring facility on ...../...../..... (d/m/yr) at .....

..... (time) with **chiefcomplaints** of :

.....

.....

.....

Summary of Management (Procedures, Critical Interventions, Drugs given for Management):

.....

.....

Investigations:

Blood Group:

Hb: Urine R/E:

Condition at time of Referral:

Consciousness:

Temp:

Pulse: BP:

Others (Specify): .....

Reason for referral:

.....

.....

.....

Information on Referral provided to the Institution Referred to: Yes /No

If yes, then name of the person spoken to: .....

Mode of Transport for Referral: Govt/Outsourced/EMRI/Personal/Others/ None.

Signature of Referring Physician/MO
(Name/Designation/Stamp)

COUNTER REFERRAL SLIP

Counter Referral Slip (level of facility)

1. The patient ..... (name) referred to us, was diagnosed as .....
2. A copy of discharge slip giving treatment, investigation and follow-up details has been given to the patients.
3. Following 'follow-up' advice needs to be carried out:
   a. Periodic check-up ..... (define weekly/fortnightly/ monthly) on following (e.g. BP, Blood sugar etc.) is advised:
   b. The patient can be issued the following drugs for a period of 15/30/45/60 days and monitor his/her..... condition/status every 15/30/45/60 days before issue of drugs.
4. Any other advice

Signature & contact no. of
Doctor referring the patient for follow-up

Medical certificate of cause of death

Name of deceased

Date of death | Day | Month | Year | Time of death | Hour | Min

Place of death

Cause of death

I hereby certify that to the best of my knowledge and belief, the cause of death was as stated below:

		Approximate interval between onset and death (Years / Months / Days)
1. Disease or condition directly leading to death	a.)	
Antecedent causes Morbid conditions, if any, giving rise to above cause, stating the underlying condition last	b.)	
	c.)	
	d.)	
2. Other significant conditions contributing to the death, but not related to the disease or condition causing it		

Please tick the relevant box

Post mortem

- PM1 ☐ Post mortem has been done and information is included above
- PM2 ☐ Post mortem information may be available later
- PM3 ☐ No post mortem is being done

Procurator fiscal/Coroner

- PF ☐ This death has been reported to the procurator fiscal/coroner

Attendance on deceased

- A1 ☐ I was in attendance upon the deceased during last illness
- A2 ☐ I was not in attendance upon the deceased during last illness: the doctor who was is unable to provide the certificate
- A3 ☐ No doctor was in attendance on the deceased

Signature

Name in BLOCK CAPITALS

Official address

Date:

For a death in hospital

Name of the consultant responsible

Counterfoil – Medical certificate of cause of death

Name of deceased

Date of death

Place of death

Please circle as appropriate				
Post mortem	PM1	PM2	PM3	
Procurator fiscal/Coroner	PF			
Attendance on deceased	A1	A2	A3	

Cause of death

I (a)

(b)

(c)

(d)

II

Date of certificate

Thank You